study suggests that the recent findings of the OHTS[2] may not be generalisable to CCT measurements taken using the Orbscan II device.

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Sir,

Retinal infarction following lipoma excision in a patient with secondary ophthalmic artery stenosis

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We present a case of ophthalmic artery stenosis manifesting after routine lipoma excision under general anaesthetic in a patient.

Case report

A 36-year-old patient presented to eye casualty with a 5-day history of acute reduction of vision in his left eye. The fall in his vision was noticed on waking up from a general anaesthetic, which was administered for excision of a large lipoma on the dorsum of the neck. There was a past history of bilateral treated retinoblastoma. It was suggested that external beam radiotherapy or possibly of plaque brachytherapy was used for treating the retinoblastoma in childhood. Unfortunately, no records of this treatment were available. Cataract extraction was subsequently performed to remove radiation-induced cataracts. Following treatment, he developed a meningioma of the right temporal lobe, which was removed surgically. He was a heavy smoker and a known case of coronary artery disease. Ocular examination revealed a visual acuity of hand movements in the right and 6/12 in the left eye. The right eye had a relative afferent pupillary defect. He was bilaterally aphakic. Fundus examination showed blurred disc margins in the left eye consistent with optic disc drusen, which were later confirmed on B scan ultrasound. Chorioretinal scarring suggestive of a regressed retinoblastoma was also visible along the superotemporal vessel. Nasal to the disc was an atrophic area with some exudates inferior to it. A refractile embolus was seen in the inferonasal artery. Fundus fluorescein angiography confirmed the optic disc drusen; the atrophic area nasal to the disc had blocked choroidal fluorescence indicating that it was the old plaque site for irradiation and an infarct inferonasal to the macula explaining the field defect. A magnetic resonance angiography showed a stenosis of the left ophthalmic artery about 2 cm from the globe (Figure 1).

A diagnosis of a retinal infarct secondary to stenosis of the ophthalmic artery was made. The infarct was probably caused by a combination of stenosis of the ophthalmic artery and a hypotensive episode during the general anaesthetic.

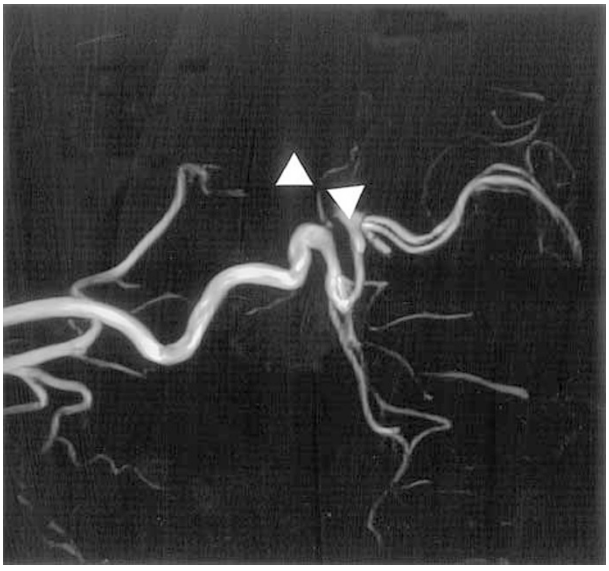

Figure 1 Magnetic resonance angiography showing stenosis of the ophthalmic artery 2 cm from the globe—marked with arrow.

Discussion

External beam radiotherapy[1] is an effective and established treatment for retinoblastoma. Radiation-induced cataract,[4] radiation retinopathy, mild keratopathy, xerophthalmia,[2] and cosmetic facial deformity[3] have all been reported following the treatment. Secondary orbital and facial nonretinoblastoma malignancies (Meningioma of the right temporal lobe as seen in the present case) in these patients are mostly radiation induced.[5] Stenosis of the intracranial arteries[6] following irradiation for craniopharyngioma, and that of vertebral arteries in the neck after X-ray treatment in childhood[7] are well known; however, stenosis of the intraorbital ophthalmic artery secondary to external beam irradiation for retinoblastoma has not been reported before. The mechanism of stenosis appears to be similar as seen in other vessels.[6] A combination of a stenosed artery, which we presume resulted from radiation-induced endothelial damage combined with an episodic drop in blood pressure during the general anaesthetic for lipoma excision, precipitated the retinal infarct in our patient.

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Sir,

An unusual case of corneal perforation with crystalline lens extrusion secondary to pseudomonas keratitis in the presence of rheumatoid arthritis

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A common complication of rheumatoid arthritis (RA) is dry eye, which can compromise the ocular surface and predispose it to infective keratitis. Both RA and infective keratitis can lead to corneal melt but this rarely results in the extrusion of intraocular contents. We report a case of spontaneous lens extrusion in a patient with dry eyes and infective keratitis.

Case report

A frail 96-year-old lady with previously well-controlled RA and dry eye presented to her GP with a 3-day history of a red and gritty dry eye. There had been no perception of light in this eye for several years due to rubeotic glaucoma secondary to central retinal vein occlusion.